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UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA, WESTERN DIVISION

AETNA LIFE INSURANCE COMPANY, AETNA HEALTH OF CALIFORNIA, INC.,

Plaintiffs,

v.

NATHAN SAMUEL YOUNG a/k/a PABLO LOPEZ; DAVID YOUNG a/k/a SANCHO LOPEZ; JOSE RICARDO TOSCANO MALDONADO; ALI BEHESHTI; MARC ADLER; ANI MIRZAVAN; ZEALIE LLC; HELPING HANDS REHABILITATION CLINIC INC; JOSER FOREVER LLC; GET REAL RECOVERY LLC; REVIVE PREMIER TREATMENT CENTER, INC.; HEALING PATH DETOX LLC; OCEAN VALLEY BEHAVIORAL HEALTH, LLC; RODEO RECOVERY LLC; SUNSET REHAB LLC; NATURAL REST HOUSE, INC; 55 SILVER LLC, 9 SILVER LLC; JOHN

Case No. 2:23-cv-09654-MCS-JPR

COUNTERCLAIMANTS GET REAL RECOVERY INC., HEALING PATH DETOX LLC, OCEAN VALLEY BEHAVIORAL HEALTH LLC, SUNSET REHAB LLC, HELPING HANDS REHABILITATION CLINIC INC., AND JOSER FOREVER LLC'S OPPOSITION TO AETNA LIFE INSURANCE COMPANY, AETNA HEALTH OF CALIFORNIA INC., AND DAVID ERICKSON'S MOTION TO DISMISS THE COUNTERCLAIMS

Judge: Honorable Mark C. Scarsi
Date: March 3, 2025
Time: 9:00 a.m.
Crtrm.: 7C

Filed concurrently with Declaration of Marc S. Williams

DOES 1 THROUGH 50; AND ABC CORPS. 1-50,

Defendants.

GET REAL RECOVERY, INC.; HEALING PATH DETOX LLC; OCEAN VALLEY BEHAVIORAL HEALTH, LLC; SUNSET REHAB LLC; HELPING HANDS REHABILITATION CLINIC, INC.; AND JOSER FOREVER LLC,

Counterclaimants,

v.

AETNA LIFE INSURANCE COMPANY; AETNA HEALTH OF CALIFORNIA, INC.; DAVID ERICKSON; ROES 1-10,

Counterdefendants.

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I. INTRODUCTION

The Court should deny Aetna Life Insurance Company, Aetna Health of California Inc. and David Erickson's (collectively "Aetna") Motion to Dismiss Counterclaims, ECF 86 ("Motion"), for a simple reason. Counterclaimants ("Providers") and the addicted individuals whose interests they represent by assignment have well-established rights under common law contract and tort principles as well as under ERISA. Aetna disregarded those rights in pursuing its sham audit. Aetna cites no legal authority allowing the course of conduct alleged: lying to Providers and miring them in pretextual and indefinite prepayment review, while inducing Providers to continue offering mental health and substance use disorder ("MH/SUD") treatment to Aetna's enrollees.

Instead, Aetna resorts to rule breaking. The Motion opens with improper references to matters outside the pleadings, to suggest Providers did something illegal or wrong. Mot. 1. If Providers did, Aetna could have promptly denied Providers' reimbursement requests using legitimate procedures and citing supporting plan documents. That is not what happened. Aetna resorted to illegal tactics, in the form of a sham prepayment audit that continues unresolved to this day.

Now Aetna argues that "two wrongs make a right." But that is not the law. Aetna cited no wrong in its sham audit notification letters ("Notices"). And Aetna had no right to direct Providers to sink time and money into a fake medical records review prior to payment, while continuing to benefit from Providers' ongoing treatment of Aetna enrollees. The common law requires that insurers not misrepresent facts, and that promises be kept. The Court should reject Aetna's latest attempt to dodge paying for addiction treatment and deny the Motion in full.

II. ARGUMENT

A. Providers Sufficiently Plead Fraud and Negligent Misrepresentation (Claims One, Two).

Providers' first claims are fraud and negligent misrepresentation. ECF 74, at 40-44 ("Counterclaims"). The elements of fraud are "(a) a misrepresentation (false

representation, concealment, or nondisclosure); (b) knowledge of falsity (or "scienter"); (c) intent to defraud, i.e., to induce reliance; (d) justifiable reliance; and (e) resulting damage." *Tenet Healthsys. Desert, Inc. v. Blue Cross of Cal.*, 245 Cal.App.4th 821, 837 (2016) (cleaned up). The elements of negligent misrepresentation differ in the scienter requirement. *See City of Atascadero v. Merrill Lynch, Pierce, Fenner & Smith, Inc.*, 68 Cal.App.4th 445, 481 (1998). Under Federal Rule 9(b), fraud must be pleaded with sufficient particularity. Aetna's focus on this last requirement is misplaced, and its salvo regarding the economic loss rule, justifiable reliance, and future conduct misses the mark.

1. Providers State the Fraud in Abundant Detail.

Providers clear the particularity bar set by Rule 9(b). *Contra* Mot. 13-14. Attaching each Notice, as Aetna demands, would result in a cumbersome pleading and waste time. As this Court noted, in cases such as this one "involving hundreds or thousands of alleged fraudulent transactions, specifying each and every transaction with the particularity ordinarily demanded by Rule 9(b) is neither practical nor required." ECF 63, at 4-5 (citation omitted).

Providers identify the author of the Notices, and allege when, where, why and how the fraudulent statements and conduct occurred. In short, Aetna began sending identical prepayment review notices via representative David Erickson in or about November or December 2022. Ctrclm. ¶59. Providers detail identifying information for relevant reimbursement claims. *Id.* Exhs. 1-2 (listing enrollee, facility, and dates of service). It's all there in black and white. Providers quote the Notices' relevant content, *id.* ¶¶99(a)-(c), and explain *how* these statements—and Aetna's subsequent conduct—misled them, *id.* ¶80, ¶¶103-109, ¶¶73-86.

The fraud dismissals Aetna cites, Mot. 12, are no match for the Counterclaims. *Aquilina v. Certain Underwriters at Lloyd's*, 407 F.Supp.3d 978, 995 (D. Haw. 2019) (complaint contained "almost no particulars"); *Semegen v. Weidner*, 780 F.2d 727, 731 (9th Cir. 1985) (claims lacked "specification of any times, dates, places or other details"). Aetna ignores Providers' detailed pleading, while bulldozing over the rule that fraud may

also rest upon misleading conduct, "not only from verbal or written statements." *Tenet*, 245 Cal.App.4th at 839.

2. Providers State Distinct Fraudulent Misrepresentations and Misconduct.

Three statements in the Notices defrauded Providers into engaging with Aetna's endless prepayment review. The statements (a) misrepresented the nature of the audit, (b) falsely promised that "all claims that you submit for reimbursement will be reviewed prior to payment," and (c) misrepresented the audit procedures that would be used. Ctrclm. ¶¶99(a)-(c). According to Aetna's mischaracterization, Providers are only concerned with Aetna's written "promise" to pay all claims. Mot. 12. But fraud may be pleaded in the alternative. 5A Fed. Prac. & Proc. Civ. § 1298 (4th ed.), n.4 ("One is not always required to elect a single theory where fraud is claimed . . .") (citation omitted). The three misrepresentations are sufficient to state a claim individually, and as a whole in the context of Aetna's course of conduct. Ctrclm. ¶80, ¶¶103-109.

Apart from glossing over the specific statements and conduct alleged, Aetna's arguments regarding "promises" to pay, Mot. 12-13, are mistaken for two reasons. First, Aetna assumes a promise is required for a fraud claim. It is not. A "misrepresentation" is required. *Tenet*, 245 Cal.App.4th at 837. Second, the Notices and Aetna's conduct did amount to at least two promises: to actually review claims in good faith and to pay all *properly documented* claims. *Sacramento Cnty. Retired Emps. Ass'n v. Cnty. of Sacramento*, 975 F. Supp. 2d 1150, 1166 (E.D. Cal. 2013) (course of conduct may show an implied promise, conduct alleged must give rise to understanding sought to be enforced).

Aetna's cases tend to prove Providers' point. In *Marchioli v. Pre-employ.com, Inc.*, an offer contained "express language" "disclaim[ing]" an intention to make a promise. 2017 WL 8186761, at *9 (C.D. Cal. June 30, 2017) (also noting "extrinsic evidence" may be introduced if a document is "ambiguous"). Aetna's Notices have no such disclaimer. The end result supports Provider's allegation of fraud: real prepayment

review would have resulted "either in a denial or a payment of the claim." *Wound Care Consultants of America, Inc. v. Health Care Serv. Corp.*, 2022 WL 209562, at *4 (N.D. Tex. Jan. 24, 2022). Aetna's sham audit resulted in neither. Ctrclm. ¶83, ¶109.

3. Fraud Covers Promised Future Conduct, and Negligent Misrepresentation Covers the Present.

"[I]n a promissory fraud action, to sufficiently allege[] defendant made a misrepresentation, the complaint must allege (1) the defendant made a representation of intent to perform some future action, i.e., the defendant made a promise, and (2) the defendant did not really have that intent at the time that the promise was made, i.e., the promise was false." *Beckwith v. Dahl*, 205 Cal. App. 4th 1039, 1060 (2012). Actionable negligent misrepresentation, however, need only "pertain to [a] past or existing material fact." *Cansino v. Bank of America*, 224 Cal. App. 4th 1462, 1469 (2014).

Providers adequately describe both Aetna's promises and statements of past or existing fact. Aetna's dual promises to review claims and to pay properly documented claims in the future are actionable fraud. *Contra* Mot. 14. Aetna's assertions about the past/current review of "data" and the nature of the audit are actionable fraud *and* negligent misrepresentation. Providers reasonably believed from the Notices (sent repeatedly over months) and from Aetna's conduct that Aetna was *presently* placing requests in prepayment review and *presently* reviewing the medical records being submitted. *See Id.* ¶65.

The plaintiff in Aetna's sole cited case, *Cty. Hospital of the Monterey Peninsula v. Aetna Life Insurance Company*, hoped that ***pre***-treatment verification of benefits ("VOB") and ***pre***-authorization, without more, amounted to misrepresentations Aetna would pay. 119 F. Supp. 3d 1042, 1048 (N.D. Cal. 2015). But Providers' fraud theory here hinges on the Notices, which were obtained ***post***-treatment and ***post***-billing.

4. Providers Reasonably Relied on the Notices Because They Were Formal Letters.

The Counterclaims state detrimental and reasonable reliance on the Notices. Aetna's argument the reliance was "unjustifiable" is unsupported by any citation and is incorrect. Mot. 11, 13. Reliance is justified if (1) the matter represented was material in the sense that a reasonable person would find it important in determining how to act, and (2) it was reasonable for the person to have relied on the misrepresentation. *Hoffman v. 162 North Wolfe LLC*, 228 Cal. App. 4th 1178, 1194 (2014). Drawing reasonable inferences in Providers' favor, the Notices—a formal letter from Aetna's Special Investigative Unit—easily satisfied these criteria. Ctrclm. ¶¶101-102. Aetna's prior history of paying further justifies Providers' reliance. *Id.* ¶¶61-64.

5. Providers Assert Various Non-Economic Losses, and Exceptions to the Economic Loss Rule Apply.

"Simply stated, the economic loss rule provides: Where a purchaser's expectations in a sale are frustrated because the product … is not working properly, his remedy is … in contract alone, for he has suffered only 'economic' losses." *Robinson Helicopter Co., Inc. v. Dana Corp.*, 34 Cal. 4th 979, 988 (2004); Mot. 11 (citing *Robinson*). In *Robinson*, the economic loss rule ("ELR") famously did *not* prevent fraud and intentional misrepresentation claims, because the torts exposed the plaintiff to "damages independent of the . . . economic loss." *Id.* at 993-94. In this case regarding Aetna's relationship to out-of-network, uncontracted Providers, the ELR is likewise inapplicable; Providers assert various independent non-contractual losses.[1]

[1] Providers suffered loss of goodwill, negative public perception, customer distrust, employee morale issues due to layoffs, and disruption to business operations. *See* Counterclaims ¶88-94. Providers seek "general damages," among other relief. Counterclaims at 60; *see Licudine v. Cedars-Sinai Med. Ctr.*, 3 Cal. App. 5th 881, 891 (2016) (general damages cover forms of detriment that are sometimes characterized as subjective or not directly quantifiable); *F.A.A. v. Cooper*, 566 U.S. 284, 296 (2012) (general damages "need not be alleged in detail and require no proof").

Second, application of the ELR depends on contracting parties' ability to allocate the risk of economic loss in the context of the sale or distribution of commercial goods. It has no logical application to out-of-network providers, *contra* Mot. 10-11, and several exceptions to the economic loss rule apply here.

For instance, the ELR does not apply if a defendant insurer refuses to pay and the parties have previously-established contractual relations. *See, e.g.*, *Fletcher v. Western Nat'l Life Ins. Co.*, 10 Cal. App.3d 376, 380(1970) ("threatened and actual bad faith refusals to make payments under the policy . . . in concert with false and threatening communications . . . [are] essentially tortious"); *Gruenberg v. Aetna Ins. Co.*, 9 Cal. 3d 566, 575 (1973) (allowing tort liability "when the insurer unreasonably . . . withholds payment"). A second pertinent exception carves out certain contracts for services. *N. Am. Chem. Co. v. Superior Court*, 59 Cal. App. 4th 764, 784 (1997) (even if parties are in privity of contract, "special relationship" exception to economic loss rule can apply if the contracts are for services and if injury is reasonably foreseeable, the "critical issue"); *see* Ctrclm. ¶¶103, 170, 213 (foreseeable and actual intent to harm MH/SUD providers). A third exception allows tort claims if the defendant fraudulently induced the contract with misrepresentations. *Finney v. Ford Motor Co.*, 2018 WL 2552266, at *9 (N.D. Cal. June 4, 2018) ("[I]t has long been the rule . . . the injured party may elect to affirm the contract and sue for fraud") (citation omitted). Any one of these exceptions is sufficient to bar the ELR.

Aetna's ELR argument fails for another reason. Providers do not claim to be in privity with Aetna vis-à-vis the ERISA plan reimbursement requests and subsequent Notices.[2] Whether to hold Aetna liable to a third party "not in privity" is a "matter of policy and involves the balancing of various factors." *Sheen v. Wells Fargo Bank, N.A.*, 12 Cal. 5th 905, 937 (2022) (citation omitted). Those factors are satisfied here: the sham

[2] Providers assert contract theories (claims three to five) only with respect to the "Non-ERISA" Notices and reimbursement requests. Ctrclm. 44-48.

audit was intended to affect Providers, Ctrclm. ¶103; the harm was foreseeable, *id.* ¶¶103, 170, 213; injury is reasonably certain, *id.* ¶¶ 87-94, 117, 142, 217; the misconduct and injury are linked; Aetna's conduct is a morally blameworthy, *id.* ¶¶87-94 (shameful results included burdening Aetna's most sick and vulnerable enrollees); and allowing the claims would prevent future harm.

6. ERISA Does Not Preempt the Fraud and Negligent Misrepresentation (or Other) Claims.

Deception. False Promises. Misrepresentation. Such misconduct has no connection to ERISA plan terms or administration. Because Providers' claims rest on this misconduct, ERISA does not preempt them.[3] Section 514(a) of ERISA only preempts state law claims that "relate to" employee benefit plans. 29 U.S.C. § 1144(a). The term "relat[e] to" means "a connection with" or "reference to" an ERISA plan. *Shaw v. Delta Air Lines, Inc.*, 463 US 85, 96-97 (1983).

The Motion contends the alleged *sham* audit "connects with" an ERISA plan.[4] But Supreme Court cases elucidating these concepts have emphasized that "relation to" and "connection with" are not limitless: "If 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run

[3] Aetna nonsensically argues preemption of Claims 4-9, Mot. 9. Claims 4-6 (contract theories) arise from *non-ERISA* reimbursement requests and subsequent notices, so cannot be preempted. Nor can Claims 7-8 be preempted. They arise under ERISA Section 502(a)(1)(B) and (a)(3), and ERISA does not preempt itself. Claim 9 is not preempted either, as a UCL claim asserted irrespective of whether the underlying plans are governed by ERISA. *See also Out of Network Substance Use Disorder Claims*, 2020 WL 2114934, at *5 (C.D. Cal. Feb. 21, 2020) (UCL claim not preempted where premised on independent obligations, including obligation to pay, obligation not to violate "state insurance law"); *David M. Lewis, D.M.D. v. William Michael Stemler, Inc.*, 2013 WL 5373527, at *6 (E.D. Cal. Sept. 25, 2013) (UCL claim based on "impacts on competition" not preempted).

[4] Aetna attempts no argument under the "reference" prong. Likewise, Aetna foregoes a "complete preemption" argument under ERISA §502(a).

its course, for 'really, universally, relations stop nowhere.'" *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995) (alteration omitted); *accord Roach v. Mail Handlers Benefit Plan*, 298 F.3d 847, 849 (9th Cir. 2002) ("the words 'relate to' . . . cannot be taken too literally."); *Shaw* 463 U.S. 85 at 100, n.21 ("Some state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan.").

Providers' claims do not implicate any factors typically creating an improper "connection" with an ERISA plan. Providers bring the state law claims as themselves (not assignees). They are not participants, beneficiaries, or fiduciaries under ERISA, so their claims classically fall outside ERISA's sphere. *Cath. Healthcare West-Bay Area v. Seafarers Health & Benefits Plan*, 321 Fed.Appx. 563, 564 (9th Cir. 2008) ("where a … provider sues an ERISA plan based on contractual obligations arising directly between the provider and the ERISA plan (*or for misrepresentations* of coverage …), no ERISA-governed relationship is implicated, and the claim is not preempted.") (emphasis added); *Blue Cross of Cal. v. Anesthesia Care Assoc. Med. Grp., Inc.*, 187 F.3d 1045, 1053–54 (9th Cir. 1999) (misconduct between plan and provider did not implicate state law claim that would subject plans to "conflicting directives" and hence to preemption); *see also Out of Network Substance Use Disorder Claims*, 2020 WL 2114934, at *5 (C.D. Cal. Feb. 21, 2020) (claim based on an independent obligation to pay provider for services rendered not preempted); *Summit Est., Inc. v. Cigna Healthcare of Cal., Inc.*, 2017 WL 4517111, at *15 (N.D. Cal. Oct. 10, 2017) (provider claims for breach of express/implied contract, negligent nondisclosure, not preempted); *Almont Ambulatory Surgery Ctr., LLC v. UnitedHealth Grp., Inc.*, 121 F. Supp. 3d 950, 965-66 (C.D. Cal. 2015) (provider's claims against plan were, at their root, based on fraudulent misrepresentations, not plan's operation); *Plastic Surgery Ctr., P.A. v. Aetna Life Ins. Co.*, 967 F.3d 218, 233 (3d Cir. 2020) (no preemption where plans were not the "critical factor" in establishing liability and claims hinged on oral offers "rather than the terms of the plan").

Here, Providers' claims depend on the Notices' false statements and the allegation that no real pre-payment medical records review was occurring at all. Ctrclm. ¶¶95-118. Because a non-audit cannot possibly "connect" with a plan, Providers' claims are far beyond the holding in Aetna's sole preemption case, *Bristol SL Holdings, Inc. v. Cigna Health & Life Ins. Co.*, 103 F.4th 597, 605 (9th Cir. 2024); Mot. 10.

The key to preemption in *Bristol* is predictable: the conduct plaintiffs challenged as fraudulent was grounded in specific plan documents. In *Bristol*, Cigna "became suspicious" that an out-of-network provider, Sure Haven, was engaging in improper fee-forgiving. *Id.* at 600. "After gathering . . . evidence that supported its suspicions," Cigna issued letters specifically "detailing its concerns" and "[*q]uoting . . . language* from the plans" regarding the plan's prohibition on forgiving enrollees' fees. *Id.* (emphasis added). Cigna stated it wouldn't pay prior claims without receipts (addressing fee-forgiving) and would systematically deny subsequent claims submitted without receipts. *Id.* In sum, the alleged audit was above-board. The plaintiffs' "overarching state law theory" thus hinged only on vague representations "during the verification and authorization calls." *Id.* at 601.

Providers' "overarching" theories and the actions they challenge here are strikingly different. Aetna issued Notices that failed to "detail" any particular concern, let alone a concern grounded in a plan document. The Notice did not "quote" from or even allude to plan terms. (Signaling a plan term now would miss the point). Providers sent the records Aetna demanded, but Aetna pretended it didn't receive them, stalled, re-requested them, and fed Providers false hope. Ctrclm. ¶80, ¶109. A *sham* audit simply cannot "connect" with ERISA plan administration.

To conclude otherwise at the pleading stage would require impermissibly drawing inferences against Providers and pre-judging disputed factual issues. Those issues are better suited for resolution on a fully developed record. *See, e.g.*, *Austin v. Boehringer Ingelheim Pharm. Inc.*, 2023 WL 3437821, at *4 (N.D. Cal. May 12, 2023) (resolution of "factual issues" important to preemption was "inappropriate" on a motion to dismiss);

Small Bus. Fin. Ass'n v. Hewlett, 2023 WL 3551061, at *6 (C.D. Cal. Mar. 30, 2023) (same).

Preempting these claims would also hand Aetna *carte blanche* to make false promises with impunity, merely because an ERISA plan exists. That would balloon ERISA preemption far beyond the limits set by the Supreme Court. *Travelers Ins. Co.*, 514 U.S. at 655 ("relate to" must stop somewhere); *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 943 (2016) ("read[ing] the presumption against pre-emption out of the law" would be "a result [that] no sensible person could have intended."). Preemption under these facts would also undercut the purposes of ERISA, "leav[ing] the provider with only one option: Sue the patient, hoping that the patient either is willing or able to pay significant, unexpected costs or has the interest and wherewithal to file suit against the insurer under section 502(a)." *Plastic Surgery Ctr.*, 967 F.3d at 233 ("the prospect . . . is unpalatable" and "would cause [damage] to the doctor-patient relationship.").

B. Counterclaimants State Contract-Based Claims as to Non-ERISA Plans (Claims Three to Six).

With respect to non-ERISA plans only, Providers assert claims for breach of express contract (Claim Three), implied contract (Claim Four), breach of the implied covenant (Claim Five), and promissory estoppel (Claim Five). The Motion ignores Claim Three. The Court should reject the arguments on the remaining Claims.

1. The Implied Contract Is Enforceable and Supported by Consideration.

An implied contract's existence and terms "are manifested by conduct." Cal. Civ. Code § 1621. "The existence of mutual consent is determined by objective rather than subjective criteria, the test being what the outward manifestations of consent would lead a reasonable person to believe." *Weddington Prods., Inc. v. Flick*, 60 Cal. App. 4th 793, 811 (1998).

In provider-insurer disputes, courts repeatedly find that manifestations of consent in addition to VOB calls or authorizations state an implied contract to pay. *See Aton Ctr.,*

Inc. v. Blue Cross & Blue Shield of Ill., 2021 WL 615051, at *4 (S.D. Cal. Feb. 16, 2021) (collecting authority, finding sufficient facts alleged on reimbursement rate to infer mutual assent); *Aton Ctr., Inc. v. Nw. Administrators, Inc.*, 2022 WL 4229307, at *4 (S.D. Cal. Sept. 13, 2022) (refusing to dismiss breach of contract (express and implied) and promissory estoppel); *Summit Est., Inc. v. Cigna Healthcare of Cal., Inc.*, 2017 WL 4517111, at *4 (N.D. Cal. Oct. 10, 2017) (permitting oral contract and parallel implied contract claim where providers alleged more than a VOB call); *Cal. Spine & Neurosurgery Inst. v. United Healthcare Ins. Co*., 2019 WL 4450842, at *4 (N.D. Cal. Sept. 17, 2019) (denying motion to dismiss express and implied contract claim, where Plaintiff asserted that "Defendant gave 'express and/or implied resultant assurances' that Plaintiff 'would be paid at least 70% of the usual and customary value of its medical services anticipated to be rendered.'").

In this case, Aetna "went far beyond . . . VOB calls" in objectively manifesting consent and intention to be bound to pay properly documented claims. Ctrclm. ¶123. Aetna had paid hundreds of claims for the same services on the same plans. *Id.* ¶¶57-59, 61-64. Aetna even had a "no authorization required" policy, and sent Notices expressly promising (1) a good faith claims procedure and review of claims, and (2) to pay the properly documented claims. *Id.* ¶¶122(a)-(d).

Aetna misapplies cases finding pre-service VOBs and authorizations insufficient to form an implied contract. Mot. 15. None of these cases involved post-treatment Notices and conduct directing Providers to submit additional records for review prior to payment. Aetna's cited dismissals also lacked allegations that the Counterclaims specifically include. *Casa Bella Recovery Int'l, Inc. v. Humana Inc.*, 2017 WL 6030260, at *4 (C.D. Cal. Nov. 27, 2017) (complaint lacked number of patients and types of treatment, and "what the agreement might have been," while seeking recovery above the plan amount); *Pac. Bay Recovery, Inc. v. Cal. Physicians' Servs., Inc.*, 12 Cal. App. 5th 200, 216 (2017) (complaint lacked type of treatment provided and the rate owed under applicable EOC);

Orthopedic Specialists of S. Cal. v. Pub. Employees' Ret. Sys., 228 Cal. App. 4th 644 (2014) (irrelevant case specific to government agencies).

Aetna's afterthought about "consideration," likewise misfires. Mot.15. *Armijo v. ILWU-PMA Welfare Plan* is about "receipt of a benefit" as an essential element for a claim of quantum meruit, not contract, 2015 WL 13629562, at *24 (C.D. Cal. Aug. 21, 2015). Consideration also exists if the promisee suffers a prejudice. "[E]ither alone is sufficient." *Property Cal. SCJLW One Corp. v. Leamy*, 25 Cal. App. 5th 1155, 1165 (2018); Ctrclm. ¶60, ¶140 (alleging benefits conferred and detriments suffered).

2. The Promissory Estoppel Claim Is Based on Clear Promises.

Promissory estoppel is "basically the same" as a contract action without consideration. *Yari v. Producers Guild of Am., Inc.*, 161 Cal. App. 4th 172, 182 (2008) (stating elements). Aetna contests only the "clear and unambiguous" promise and "reasonable" reliance elements. Mot. 17.

Providers' estoppel claim focuses on two distinct promises in the Notices: (1) Aetna would engage in a bona fide review of medical records submitted; and (2) Aetna would pay properly documented claims. VOB calls informed Providers of the requisite reimbursement rate in enrollees' evidence of coverage, and the Notice promised review prior to payment. Ctrclm. ¶149-50, 52. Both promises are clear enough to state an estoppel claim. *See Aton Ctr.*, 2021 WL 615051, at *6 (allowing promissory estoppel claim based on misrepresentation of rate).

Again, Aetna summons cases in which plaintiffs included only threadbare allegations of VOB calls or prior authorizations. Mot. 17-18; *Avanguard Surgery Ctr., LLC v. Cigna Healthcare of Cal., Inc.*, 2020 WL 5095996, at *3 (C.D. Cal. Aug. 28, 2020) (provider referenced only unspecified communications "including telephone calls requesting VOB"). And again, none of Aetna's authorities involved post-treatment and post-billing notices. Mot. 16; *Laks v. Coast Fed. Sav. & Loan Assn.*, 60 Cal. App. 3d 885 (1976) (dealings with lending institutions)).

Aetna's contention that the Notices did not specify a particular rate of reimbursement ignores the unique circumstances of the industry: the required reimbursement rate is pre-determined. The Notices didn't *need* to specify a particular rate, because Aetna committed to paying at least the rate in each enrollees' Evidence of Coverage ("EOC"). *See Pac. Bay Recovery, Inc.*, 12 Cal. App. 5th at 212. And here, Providers have alleged both billed rates and EOC rates with sufficient particularity. Ctrclm. ¶52; Exhibits 1, 2.

With respect to reasonable reliance, Aetna cites no case involving promissory estoppel. Mot. 18. Aetna never explains how the Notices "contradicted" themselves. Mot. 18. Providers incorporate their earlier reasonable reliance points, *supra* Part II.A.4.

3. The Implied Covenant Claim Is Appropriate.

Providers assert an implied covenant claim due to the essence of the breach: Aetna's bad faith in receiving and reviewing records towards decision and payment. The covenant requires each party to do "everything that the contract presupposes that he will do to accomplish its purpose," 1 Witkin, Summary 11th Contracts §822 (2024), and may remain with the underlying contract claim. *TML Recovery, LLC v. Humana Inc.*, 2019 WL 3208807, at *3 (C.D. Cal. Mar. 4, 2019) (declining to dismiss implied covenant claim where underlying contract claim survived).

C. <u>Providers Sufficiently Plead ERISA Violations (Claims Seven, Eight).</u>

Providers assert violations of ERISA Sections 502(a)(1)(B) (Claim Seven), and Section 502(a)(3) (Claim Eight), in their capacities as assignees. Ctrclm. 49-55. Section 502(a)(1)(B) permits recovery of benefits due under the terms of the plan. Section 502(a)(3) is a "catchall" permitting injunctive relief for violations of ERISA's standards of conduct.

1. Providers Have Standing By Virtue of Valid Assignments and Aetna's Waiver of Any Plan Non-Assignment Provisions.

Aetna enrollees validly assigned their ERISA claims to Providers by executing standard assignment contracts upon admission to the facilities. *Id.* ¶158. Each Provider

as assignee "stands in the shoes of the assignor, and, if the assignment is valid, has standing to assert whatever rights the assignor possessed." *Misic v. Bldg. Serv. Emps. Health & Welfare Trust*, 789 F.2d 1374, 1378, n.4 (9th Cir. 1986).

The Counterclaims allege valid assignments and waiver of any anti-assignment clauses. Ctrclm. ¶¶158-162. During meet and confers, Providers cooperated sharing their standard assignments, even before the opening of discovery. Mot. 5-6, Ex. A, B. Aetna concedes that the assignments do give Providers the right to "claims payments," *id.* at 6-7, but now quarrels about plan anti-assignment provisions and injunctive relief. Aetna is wrong on both points.

First, if a plan administrator fails to raise anti-assignment provisions during claims processing as a basis to deny benefits, the suing assignee can plead waiver. *Beverly Oaks Physicians Surgical Ctr., LLC v. Blue Cross & Blue Shield of Ill.*, 983 F.3d 435 (9th Cir. 2020). "A plan administrator may not fail to give a reason for a benefits denial during the administrative process and then raise that reason for the first time when the denial is challenged in federal court." *Harlick v. Blue Shield of Cal.*, 686 F.3d 699, 719 (9th Cir. 2012); *accord Spinedex Physical Therapy USA Inc. v. United Healthcare of Ariz., Inc.*, 770 F.3d 1282, 1296 (9th Cir. 2014) (administrator may not "hold in reserve a … reasonably knowable reason for denying a claim" then give that reason for the first time in court). Here, Providers conspicuously allege waiver. Ctrclm. ¶159. At all times, Aetna was aware Providers were acting as assignees. *Id.* ¶160-162. Aetna's own Amended Complaint admits that in "claims forms submitted to Aetna" Providers "represented that they had obtained assignments of benefits from Aetna members" and are therefore "subject to the terms of the ERISA plans." ECF 39 ¶203. Any anti-assignment provision is thus waived.

Second, the scope of the assignments is sufficient for Providers to assert a 502(a)(3) claim for injunctive relief in connection with the recoupment of benefits. The document heading is clearly "Assignment of Benefits" (plural) and states Providers may act in "any proceeding that may be necessary to seek payment." ECF 86-3; *Almendarez-*

Torres v. United States, 523 U.S. 224, 234 (1998) ("We also note that 'the title of a statute and the heading of a section' are 'tools available for the resolution of a doubt' about the meaning of a statute." (citation omitted)); *Conn. State Dental Ass'n v. Anthem Health Plans, Inc.*, 591 F.3d 1337, 1352 (11th Cir. 2009) ("[A]n assignment furthers ERISA's purposes only if the provider can enforce the right to payment.").

The 502(a)(3) claim is an alternative ground for and is necessary to obtaining the payment of benefits. ERISA Section 502(a)(3) is merely the statutory vehicle for Providers' Mental Health Parity and Addiction Equity Act ("MHPAEA" or "Parity Act") claim. Ctrclm. ¶¶182-88; *Christine S. v. Blue Cross Blue Shield of N.M.*, 428 F. Supp. 3d 1209, 1217, 1229 (D. Utah 2019) (distinguishing case Aetna relies on, *Varity Corp. v. Howe*, 516 U.S. 489 (1996), and holding plaintiffs could "only bring their Parity Act cause of action" under 502(a)(3), and declining to dismiss 502(a)(3) "claim seeking to enforce the Parity Act" where the claim is "alternative to, rather than duplicative of" the 502(a)(1)(B) denial of benefits claim."); *Galutza v. Hartford Life & Acc. Ins. Co.*, 2008 WL 2433837, at *2 (N.D. Okla. June 12, 2008) (adopting a "middle ground" in which the plaintiff "ought to be permitted to join the two claims until such time as it may be determined whether [Section 502(a)](1)(B) affords him adequate relief"). Contrary to Aetna's Motion, it is not a claim for "fiduciary breach." Mot. 6. The 502(a)(3) claim is merely an alternate theory permitting recovery for the same harm.

2. Providers Need Not Plead Exhaustion and Adequately Allege Futility of Remedies.

Exhaustion of plan remedies, Mot. 8, is a judicially created affirmative defense unavailable to Aetna at this point. *Norris v. Mazzola*, 2016 WL 1588345, at *5-6 (N.D. Cal. Apr. 20, 2016) (collecting cases). Plans only move to dismiss on this ground in "the rare event" that non-exhaustion is "clear" on the pleading's face. *Albino v. Baca*, 747 F.3d 1162, 1166 (9th Cir. 2014). Otherwise, it is a summary judgment issue. *Id.* at 1166.

Second, exhaustion is inapplicable to alleged statutory violations. The doctrine cannot bar Providers' Section 502(a)(3) claim. *Fujikawa v. Gushiken*, 823 F.2d 1341, 1345 (9th Cir. 1987) (exhaustion "not required" for statutory violation).

Third, courts require exhaustion only if the plan unambiguously demands it. *Spinedex v. United Healthcare of Arizona, Inc.*, 770 F.3d 1282, 1299 (9th Cir. 2014). Here, the Counterclaims do not concede there is an unambiguous exhaustion requirement in any plan. Aetna does not provide any EOBs or denials sent to Providers informing them of such a requirement. And Aetna's Notice merely stated Providers "may" pursue an appeal. ECF 86-7; *In re Out-of-Network Substance Use Disorder Claims Against UnitedHealthcare*, 2021 WL 8532067, at *4 (C.D. Cal. Apr. 14, 2021) (exhaustion not required because, as here, providers lacked access to plan documents and notice merely alluded to "right" of appeal).

Finally, even if Aetna's communications to Providers included an unambiguous exhaustion requirement (they did not), Providers adequately plead one or more exceptions. Providers needn't pursue administrative remedies at the same company presently suing them and their owner (personally), for fraud and conspiracy. Aetna's initiating lawsuit, without more, is enough "factual support" to excuse exhaustion. *Laborers' Pension Fund v. Etolen & Buchanan, Inc.*, 2012 WL 3581178, at *3-4 (N.D. Ill. Aug. 17, 2012) (scolding plan that it "proceeded to federal court in the first instance" and is "here because it chose to sue" and can "hardly expect the defendant [it has] sued to forego a vigorous defense that includes the assertion of any claims"); *DeMatte v. Brotherhood of Industrial Workers' Health and Welfare Fund*, 1996 WL 764540 (M.D. Fla. 1996) (excusing exhaustion as futile, where plan alleged wife engaged in fraudulent behavior and a conspiracy to alter records and plan would be biased).

Exhaustion may also be excused if a plan administrator fails to comply with ERISA claims procedures, and that failure goes "beyond mere de minimis violations." *Spindex*, 770 F.3d at 1299. Providers list examples of Aetna's lawlessness in this regard. Ctrclm. ¶70, ¶¶81-82, ¶118. Processing claims without decision for years violates

ERISA. 29 C.F.R § 2560.503(g), (f)(1), (f)(2)(iii); *Armijo v. ILWU-PMA Welfare Plan*, 2015 WL 13629562, at *6 (C.D. Cal. Aug. 21, 2015) (allegations regarding exhaustion do not require particularity); *Almont Ambulatory Surgery Ctr., LLC v. UnitedHealth Grp., Inc.*, 99 F. Supp. 3d 1110, 1179, 1181-82 (C.D. Cal. 2015) (no exhaustion required where plaintiff alleged unreasonable claims procedures that violated "full and fair" review requirement, 29 U.S.C. § 1133(2)). Any administrative remedies are thus "deemed" exhausted. *Id.* ¶¶173-177 (citing 29 C.F.R § 2560.503-1(l)); *Spinedex*, 770 F.3d at 1299.

3. Providers Specify the Relevant Plan Terms.

To state a claim under ERISA Section 502(a)(1)(B) for recovery of plan benefits, "a plaintiff must allege facts that establish the existence of an ERISA plan as well as the provisions of the plan that entitle it to benefits." *Almont Ambulatory Surgery Ctr., LLC*, 99 F. Supp. 3d at 1155. In *Almont*, the court carefully reviewed four prior decisions addressing the degree of specificity required when pleading plan violations. *Id.* at 1155-57. Ultimately, *Almont* dismissed the ERISA claims with leave to amend because the plaintiffs merely alleged "no plan terms justified the failure to pay" and did "not actually allege that the specific services they provided to the patients at issue were covered. . . or describe the terms that would support such coverage." *Id.* at 1158. The Court found the case was "a close call," especially given United's failure to provide plan documents, and provided leave to amend as follows:

> Plaintiffs will have to plead that for each plan, the terms of the plan: (1) **provide coverage** for each of the procedures at issue in this case; and (2) dictate that these covered services **would be paid according to a specific reimbursement rate** (such as the reasonable and customary fees for services charged by outpatient surgical centers), which must be specified. Plaintiffs should then allege that Defendants **failed to reimburse** for the covered services provided by Plaintiffs according to this reimbursement rate provided in the plans.

Id. at 1158-59. (emphasis added). Crucially, the Court allowed plaintiffs to allege terms "on information and belief" because they lacked "access to plan documents." *Id.*

Providers include each of the allegations the *Almont* court required, and more. The Aetna enrollees treated were on employer-sponsored ERISA plans. Ctrclm. ¶34. Providers are out-of-network and offered covered mental health and substance use disorder treatment that would be reimbursed at specific rates, for instance 125% of Medicare. *Id.* ¶¶49-53. Providers offered three levels/types of treatment, all of which were covered by the plans. *Id.* ¶54.[5] Providers were certain the MH/SUD treatment was covered, because Aetna initially paid claims for these treatments under the same plans without incident, at consistent rates. *Id.* ¶¶61-63. "Upon information and belief," the amounts paid were consistent with the rates reflected in the enrollees' evidence of coverage. *Id.* The Counterclaims go further by listing enrollee identifying information, facilities attended, and dates of service. *Id.* Exs. 1, 2. It is hard to fathom what else Aetna expects.

Grasping for any pretext for dismissal, Aetna quotes *Almont* without context, Mot. 7-8, and ignores its disposition: leave to allege on information and belief (*i.e.*, without precise quotation) the relevant plan terms. 99 F. Supp. 3d at 1158-59. Does Aetna really want repetitive citation to each of the one-hundred-plus enrollees' two-hundred-page plan documents, which only Aetna possesses? If so, none of its citations support that unreasonable demand. Mot. 8; *Villalobos v. Blue Shield of Cal. Life & Health Ins. Co.*, 2022 WL 341134, at *1 (C.D. Cal. Jan. 4, 2022) (single plaintiff failed to "identify any specific term" demonstrating the plan's treatment); *Bates v. Blue Shield of Cal.*, 2019 WL 2177641, at *1 (C.D. Cal. May 17, 2019) (single plaintiff vaguely alleged entitlement to benefits due under "lawful plan terms and provisions"). Unlike the

[5] The Motion attaches a plan document that supports this allegation. ECF 86-6 at 19-18, 70-72 (ECF pagination) (describing coverage of inpatient and outpatient treatment of mental disorders and substance abuse).

plaintiffs in *Villalobos* and *Bates*, Providers did specify relevant plan terms. And even Aetna's own authority recognizes that a plaintiff "need not recite every relevant term of every relevant plan." *ABC Servs. Grp., Inc. v. Aetna Health & Life Ins. Co.*, 2023 WL 6532648, at *1 (9th Cir. Oct. 6, 2023) (faulting plaintiffs for lack of specificity in their pleading only after "years of litigation and multiple amended complaints" in a case involving "dozens of insurers" with "distinct plans").

Aetna's "plan documents" argument is also inequitable. At meet and confers prior to the Motion and at Aetna's request, Providers voluntarily provided sample assignments, before the opening of discovery. In return, Providers requested relevant plan documents from Aetna. Williams Declaration ¶¶3-6. Aetna never responded. The Motion revealed to Providers for the first time an exemplar summary plan description. *Id.* ¶7. Aetna selectively revealed this document to try and exploit an anti-assignment clause, while glaringly omitting the plan Evidence of Coverage (EOC), which would specify the reimbursement rates to which Providers are entitled as a matter of contract. Since then, Providers handed Aetna 160 more assignments, concurrently with Providers' initial disclosures, and again requested complete plan documents. *Id.* ¶¶8-10. Six days later and only after Providers' follow-up, Aetna told Providers it would provide no plan documents without an RFP. *Id.* ¶¶11-12. Under these circumstances, Providers have alleged more than enough. The Court should not reward Aetna for hiding the ball.

D. Providers Assert Independent Harms Conferring UCL Standing (Claim Nine) and Allege Several Plausible Theories of Unlawful Behavior.

Providers allege that they were independently harmed by Aetna's violation of the Unfair Competition Law (UCL).[6] The California Supreme Court has held—against Aetna—that diverted staff resources and diverted time, without more, confer UCL standing. *Cal. Med. Assn. v. Aetna Health of Cal. Inc.*, 14 Cal. 5th 1075, 1089 (2023)

[6] The UCL claim contains no statement that "for this claim, Providers are suing Aetna as the assignees of Aetna enrollees' ERISA-covered benefits." *Compare* Ctrclm. ¶180.

(standing also conferred by "out-of-pocket expenditures for which no value has been received"). Providers suffered the "direct" harm of lost resources irrespective of their status as assignees. Ctrclm. ¶217; *Kwikset Corp. v. Superior Court*, 246 P.3d 877, 885 (Cal. 2011) (standing also conferred by being "required to enter" otherwise unnecessary transaction, costing money); *Out of Network Substance Use Disorder Claims* , 2020 WL 2114934, at *9 (permitting out-of-network providers to proceed on UCL "unlawful prong" theory premised on Parity Act violations).

Aetna's arguments regarding the Knox-Keene Act ("KKA") and Parity Act cannot be decided at this time. Mot. 20. With respect to the KKA, Aetna demands that the Court assume—without any application for judicial notice—that Aetna is an insurer subject to the exception created by Health & Safety Code §1343(e)(1). But the Court cannot make that assumption,[7] and Aetna (including David Erickson), is not. *Keith Feder, M.D., Inc. v. Aetna Life Ins. Co.*, 2024 WL 1641987, at *2 (C.D. Cal. Mar. 4, 2024) (finding a single entity—Aetna Life Insurance Co.—excepted from the KKA, only after considering supporting request for judicial notice). Similarly, it is too early to ascertain whether all the relevant Aetna plans are "fully self-funded," *Oneto v. Watson*, 2024 WL 2925310, at *5 (N.D. Cal. June 10, 2024); Ctrclm. ¶120 (Providers believe some plans are *not* self-funded). And the facts alleged are sufficient to infer Aetna is managed by the DMHCS as a health care service plan subject to the KKA. *Id.* ¶31 n.1 (referencing 191 DMHCS enforcement actions against Aetna Health California).

Aetna's arguments regarding substantive violations alleged under the UCL claim also fail. Mot. 20-21. Providers allege facts sufficient to conclude there was no real purpose for requesting medical records repeatedly, and the requests were not "reasonably necessary" to the audit. Ctrclm. ¶195-96 (citing Health & Safety Code § 1367.01). Likewise, the UCL claim functions even without the single erroneous KKA citation

[7] *See* CDI Website Business License Search, https://cdicloud.insurance.ca.gov/cal (returning no results for Aetna Life and for Aetna Health).

Aetna raises, Section 1371(b). Section 1371.35(g)'s timeliness requirements, meanwhile, do apply: the face of the Counterclaims (and of the Notices) contain *no* evidence of Providers having engaged in fraud or misrepresentation.

The Parity Act authorities Aetna cites, Mot. 19 n.15, are outdated and do not dispose of the UCL claim either. In 2024 the Ninth Circuit reversed in relevant part the decision upon which Aetna relies and held that Parity Act claims of "improper internal process" need only allege "something more" than a denial, and may rely on government reports and investigations. *Ryan S. v. UnitedHealth Grp., Inc.*, 98 F. 4th 965, 973 (9th Cir. 2024). In addition to citing multiple government reports, Ctrclm. ¶44, Providers allege more: a systematic sham audit. *See id.* ¶¶184-191.

E. To the Extent Any Claim Is Insufficiently Stated, the Court Should Grant Leave to Amend.

In the event the Court finds a claim deficient in any regard, Providers respectfully request leave to amend, with adequate time to address any identified deficiency. *See Lopez v. Smith*, 203 F.3d 1122, 1127 (9th Cir. 2000) (leave to amend appropriate unless complaint "could not possibly" be cured).

III. CONCLUSION

For the foregoing reasons, the Motion should be denied.

Dated: February 4, 2025

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LOCAL RULE 11-6.1 CERTIFICATION

The undersigned, counsel of record for Defendants Nathan Young, David Young, Get Real Recovery, Inc., Healing Path Detox LLC, Ocean Valley Behavioral Health, LLC, Rodeo Recovery LLC, Sunset Rehab LLC, Natural Rest House, Inc., 55 Silver LLC, 9 Silver LLC, Helping Hands Rehabilitation Clinic Inc., and Joser Forever LLC, certifies that this brief contains 6,888 words, which complies with the word limit of L.R. 11-6.1 and the Initial Standing Order issued in this action (ECF 18 ¶8(4)-(5)).

Dated: February 4, 2025

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